Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $194.00 for dates of service 03/15/01 through 04/16/01.

   b. The request was received on 02/14/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 04/01/02
   b. HCFA(s)
   c. EOB
   d. Reimbursement data
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and/or Response to a Request for Dispute Resolution dated 04/11/02
   b. HCFA(s)
   c. EOB
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/09/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 04/12/02. The response from the insurance carrier was received in the Division on 04/15/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

The carrier claims that range of motion / muscle strength testing codes (95851/ 97750) are included in a global code which accurately describes the entire procedure(s) performed.

In this denial the carrier refers to 99213 as a more comprehensive code, which encompasses code 95851 and 97750. 99213 does not accurately code for the services performed on the date of service in question.

BILLING CODE 99213 – ESTABLISHED PATIENT E/M

The medical fee guideline states that to bill 99213, 'Physicians typically spend 15 minutes face-to-face with the patient and/or family.'

BILLING CODES 95851/97750 RANGE OF MOTION/MUSCLE RESTING

The range of motion and muscle testing procedures have unique billing codes by virtue of the procedures being separate and distinct services. Range of motion and muscle testing require approximately 20 minuets[sic] to perform in excess of the 15 minutes spent for a 99213 evaluation and management code.

Insurance carrier denies code 97110 based on TWCC fee guideline

THE CARRIER REDUCED THE NUMBER OF UNITS OF ACTIVE THERAPY FROM 3 TO 1, AND FAILED TO PRVIDE[sic] SUFFICIENT RATIONAL[sic] TO SUPPORT THE REDUCTION OF SERVICES THAT WERE BILLED IN ACCORDANCE WITH ESTABLISHED TWCC FEE GUIDELINE MAR.

PHYSICAL MEDICINE DID NOT EXCEED THE ALLOWED NUMBER OF UNITS DEEMED BY THE COMMISSION AS REASONABLE AND CUSTOMARY PER DAY."

2. Respondent:

"For DOS 3/15/2001, 4/6/2001, and 4/16/2001, the provider has over-billed the services rendered on this date and not provided sufficient documentation to support the charges billed on this date. The documentation provided does not indicate the identity of the person performing the services. The Carrier's EOB denied the 95851 service as being 'incidental to the related primary procedure billed.' In other words, this CPT code (as well as 97265, 97032, and 97110) are included in the services that are provided in an office visit. The provider has erroneously billed an office visit in addition to multiple physical medicine charges. The Carrier paid the office visit and several other physical medicine charges, but denied the reimbursement of CPT code 95851 on the previously stated basis. Thus, the Carrier is actually entitled to a refund in this case, and the Carrier requests that an immediate refund be ordered by the TWCC MRD. Joint mobilizations and manipulations performed in a chiropractic office visit are essentially the same thing.

The Carrier's interpretation of allowable billing and the manipulation/mobilization issue is fully supported by the soon-to-be adopted billing initiatives.

For DOS 3/29/2001, the provider has over-billed the services rendered on this date and not provided sufficient documentation to support the charges as billed on this date. The documentation provided does not indicate the identity of the person performing the services and thus the provider is not entitled to reimbursement sought. The Carrier's EOB denied the additional 97110 charge because the documentation did not support that the provider provided 2 units of 97110 for a total of $70.00 reimbursement. According to the fee schedule, the provider is only entitled $35.00 per unit, thus the Carrier reimbursed the provider for $35.00 for the one unit provided, not the $70.00 billed."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 03/15/01, 03/29/01, 04/06/01, and 04/16/01.

2. The denials listed on the EOBs are "2-BY CLINICAL PRACTICE STANDARDS, THIS PROCEDURE IS INCIDENTAL TO THE RELATED PRIMARY PROCEDURE BILLED. 1-THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY ALLOWANCE."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$ (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
03/15/01 04/06/01 04/16/01	95851	$36.00 $36.00 $36.00	$0.00 $0.00 $0.00	2 2 1	$36.00 (each extremity)	MFG E/M GR(IV)(A)(1) CPT descriptor	**2-"By clinical practice standards, this procedure is incidental to the related procedure billed."** CPT code 95851 "When the doctor performs a complete diagnostic service during an office visit (e.g. technical and professional component of a study), both components of the service shall be reimbursed in addition to the office visit." Medical documentation indicates that the services were rendered. Therefore, reimbursement in the amount of **$108.00 is** recommended.
03/29/01	97110	$70.00	$35.00	1	$35.00 (each 15 minutes)	MFG MGR; (I)(10)(a)	The dispute packet does not contain any documentation for this CPT code, or for the date of service in dispute. Therefore, additional reimbursement is not recommended.
Totals		$178.00	$35.00				The Requestor **is** entitled to reimbursement in the amount of **$108.00.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $108.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 18th day of June 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

Mb/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.